FINAL REPORT
OF THE
HEALTH FINANCE COMMISSION

Indiana Legislative Services Agency
200 W. Washington St., Suite 301
Indianapolis, Indiana 46204-2789

November 2008

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2008

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Health Finance Commission

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November 1, 2008

A copy of this report is available on the Internet. Reports, minutes, and notices are organized by committee. This report and other documents for this Commission can be accessed from the General Assembly Homepage at http://www.in.gov/legislative/.

FINAL REPORT

Health Finance Commission

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Indiana General Assembly enacted legislation (IC 2-5-23) establishing the Health Finance Commission to study health finance in Indiana. The Commission may study any topic (1) directed by the chairperson of the Commission; (2) assigned by the Legislative Council; or (3) concerning issues that include the delivery, payment, and organization of health services and rules that pertain to health care delivery, payment, and services that are under the authority of any board or agency of state government.

The Legislative Council assigned the following additional responsibilities to the Commission: (1) collect and analyze statistics and examine employment and quality-of-care issues related to home health workers as proposed in HR 102; (2) study wages, benefits, and working conditions of persons who provide in-home care and related services to senior citizens and persons with disabilities as proposed in SR 43; (3) review the present policies, costs, trends, and incentives to encourage more people to enroll in long-term care insurance as proposed in HR 107; and (4) study issues concerning requirements for the Division of Family Resources, child care providers, and children served by childcare providers related to childhood lead poisoning prevention as required by SEA 143-2008.

II. INTRODUCTION AND REASONS FOR STUDY

SEA 164-2008 requires the Health Finance Commission to review the feasibility and costs of allowing qualified individuals to participate in the Indiana Check-up Plan if the state does not provide funding for the coverage of the qualified individual.

Reports Required

The State Department of Health (ISDH) is required by SEA 207-2007 to report to the Health Finance Commission not later than September 1 of 2007 and 2008 concerning the implementation of IC 16-40-5 (concerning the progress of implementing adverse event reporting).

HEA 1468-2007 requires ISDH to evaluate the current immunization data registry system in consultation with health care providers, and to determine ways to make the registry easier for health care providers to report to and use. The ISDH is required to report orally to the Commission no later than November 1, 2008, on the Department's recommendations and progress toward making the immunization registry easier to use.

III. SUMMARY OF WORK PROGRAM

The Commission met four times at the State House in Indianapolis during the 2008 interim.

The first meeting was held August 20, 2008. The meeting was dedicated to two topics; wages, benefits, and working conditions of home health service workers, and incentives for the purchase of long-term care insurance. Members and representatives of the Service Employee's International Union (SEIU) discussed current wages and benefits paid for home care workers. SEIU also offered testimony regarding the cost effectiveness of keeping patients in their homes and compared Indiana's long-term care statistics with those of the state of Washington. Home health care providers offered testimony regarding the roles of nonlicensed home care workers and presented statistics regarding wages, benefits, reimbursement for services, and the growing need for qualified home care workers. Rebecca Vaughan, Director of the Indiana Long-Term Care Partnership gave an update on the program and recent developments in the federal program. Representatives from the insurance industry discussed what benefits long-term care insurance products offer and how the products could be improved and made more affordable.

The second meeting was held September 3, 2008. The Commission heard updates on the implementation of SEA 493-2003, concerning the home and community-based services continuum of care and the state trauma care network. Mitch Roob, Secretary of the Family and Social Services Administration (FSSA) reported on actions taken by FSSA on each section of the bill noting that FSSA had implemented all sections of the bill. There was Commission discussion regarding reauthorization of sections of SEA 493 that had expired. As an extension of his report on SEA 493, Secretary Roob described a proposal to adjust nursing facility reimbursement to provide incentives for nursing facilities to concentrate on high-needs patients rather than admitting lower-needs patients who could appropriately utilize home and community-based services. Two industry representatives discussed nursing facility reimbursement issues. Medical directors and administrative directors of trauma centers located in the state presented information on the clinical and administrative requirements for operating a certified trauma center. Several individuals testified regarding the lack of a certified trauma center in Northwestern Indiana. The ISDH reported on trauma system development activities authorized by P.L. 155-2006.

The third meeting was held September 24, 2008. The Commission heard testimony regarding lead poisoning prevention requirements for child care settings, the exclusion of chiropractic services from the Healthy Indiana Plan (HIP), and HIP billing problems that podiatrists have experienced. Dr. Joan Duwve of the ISDH testified regarding the effects of lead exposure on children and cited statistics on the number of children in out-of-home care and studies concerning the incidence of lead hazards found in child care settings. Melanie Brizzi, a consultant for the Bureau of Childcare expressed the concerns of the Bureau with regard to over-burdening licensed childcare providers with

requirements that might result in an economic disadvantage for these high-quality childcare providers. Lead poisoning prevention advocates defined primary and secondary prevention activities, described what lead hazards might be present in a child care setting, and discussed components of a program to control or eliminate lead poisoning risks before children are exposed. Representatives of Indiana chiropractors testified that the FSSA was in the process of promulgating a rule to implement the HIP program that excluded chiropractic services and that chiropractors would like to be included in the plan services. A representative of the Podiatric Medical Association discussed concerns about podiatrists' claims being denied for payment by one of the HIP insurance providers.

The fourth meeting was held October 22, 2008. The meeting was for the purpose of considering and approving legislative recommendations and the Commission's final report. The Commission heard a defense of the FSSA Eligibility Modernization Project, an update on the Indiana Check-up Program/Healthy Indiana Plan, an initial proposal for potential changes to the Medicaid program, testimony on the proposed MCO contract pharmacy carve-out, and an evaluation and demonstration of the ISDH Immunization Registry. FSSA also reported that there is currently no way to allow unsubsidized individuals to participate in the HIP program under the terms of the Medicaid waiver.

IV. SUMMARY OF TESTIMONY

The Commission heard testimony on several issues over the course of the interim. To read a more complete account of this testimony and other matters considered by the Commission, the minutes of the Commission's four meetings can be found on the Commission's website (http://www.in.gov/legislative/interim/committee/hfco.html), or copies may be obtained by contacting the Legislative Information Center of the Legislative Services Agency.

Wages, Benefits, and Working Conditions of Home Health Service Providers

The Commission heard testimony from Wayne Morgan, CNA, a home health worker from Gary describing the services that home health aides perform. Wages and benefits such as affordable health insurance were anecdotally described. The treatment of transportation expenses of home health workers was also discussed.

Consumers of in-home care services testified that high staff turnover was a problem for consumers since it requires constant training of new attendants. Consumers also testified about the difficulty of negotiating the existing system for handling complaints about service providers and the administrative complexity of the state's self-directed care option.

Maggie Laslo, Director of Governmental Affairs, Service Employees' International Union described two models of in-home service provision, care provided through an agency,

and consumer-directed or self-directed provision of care. She testified that in order to be more efficient, Indiana needs to shift the provision of long-term care from the institutional model to the in-home care model. Ms. Laslo discussed the ongoing and expanding need for home care service workers in order to achieve this shift. She discussed actions the state should take in order to recruit and retain sufficient numbers of home health workers. She emphasized that the consumer-directed care model could be used to expand the number of home health workers available and is currently underutilized in Indiana in comparison to other states.

Ms. Denise Gaither, a consultant from the state of Washington presented a statistical comparison of the provision of long-term care services in Washington and Indiana. She described Washington's worker training requirements, the complaint investigation process, cost information, and the Home Care Quality Authority.

Todd Stallings of the Indiana Association for Home & Hospice Care described the roles of nonlicensed home care workers and presented national labor statistics for personal care attendants and home health aides. He reviewed the results of an informal survey conducted by the Association. Mr. Stallings recommended health insurance reform to allow the pooling of small employers' health insurance risk to address the cost of home health workers benefits and a revision of Medicaid reimbursement methodology to be more responsive to providers' increasing costs.

Tim Kennedy, testifying on behalf of the Indiana Hospital Association said that hospital-employed home health workers are provided benefits as hospital employees. He stated that there is currently competition for home care workers and the number needed to fill the demand is expected to increase substantially.

Claudia Chavis, the proprietor of a small, private personal service and home health agency commented that agencies have little or no input into what they are paid for the services they provide - Medicare, Medicaid, and private insurers set the rates. She noted that employers also have other expenses such as unemployment compensation insurance and other payroll taxes that are linked to the size of the payroll, limiting what agencies can pass through to their employees as compensation.

Al Tolbert, Executive Director of the Southern Indiana Center for Independent Living, discussed the wages and benefits offered by his agency. He commented on the expense of training requirements for home care and attendant care workers as well as safety provisions such as tuberculosis testing and criminal history background checks. Mr. Tolbert also discussed barriers to the provision of in-home services and testified that three counties have no home care providers.

Long Term Care Insurance Incentives

Rebecca Vaughan, Director of the Indiana Long-Term Care Partnership presented a review of the program and an update of the 2005 federal initiative to expand the Long-

Term Care Partnership program to additional states. She testified that the Department of Insurance is developing a marketing concept to promote the purchase of long-term care insurance.

Representatives of the insurance industry presented information on long-term care insurance products, what services might be covered, average costs, policy options that influence the cost of the product, and options being developed to improve the product cost such as couples discounts. Addressing the issue of affordable long-term care insurance, insurers are looking at more flexible hybrid products such as life insurance policies with a long-term care rider attached. It was suggested that the state could encourage product flexibility by updating long-term care statutes and regulations as well as increasing the current income tax deduction to a tax credit for long-term care premiums. It was also suggested that as more states are added to the Long-Term Care Partnership Program, Indiana should opt for product reciprocity with products sold in the new state programs.

SEA 493-2003 Long-Term Care Continuum of Care Expansion Update

Mitch Roob, Secretary of the Family and Social Services Administration, reviewed each section of the bill that required action by FSSA. He testified that FSSA had implemented all sections of the bill including sections that had expired. With regard to the need to reauthorize certain expired sections of the bill, he stated that certain sections could be implemented under existing administrative discretion. He added later that it could be helpful to have statutory authority for the self-directed care option.

Secretary Roob discussed the need to increase the number of individuals receiving in-home services and moving nursing facility residents with lower acuity levels to in-home services. He reported on proposed adjustments to nursing facility reimbursement intended to motivate nursing facilities to concentrate on serving high-needs patients while discouraging them from admitting lower-needs patients who might be more efficiently served in the community. He stated that FSSA is investigating modifications to the Quality Assessment fee distribution and nursing facility reimbursement methodology. He added that the system capacity of in-home services limits the number of individuals that can be served in that setting. He estimated that it will take a decade to develop sufficient capacity to achieve in-home care statistics comparable to the national average for all states.

Vince McGowen of Hoosier Owners and Providers for the Elderly (HOPE) agreed conceptually with Secretary Roob's remarks concerning the shift in reimbursement to discourage facilities from admitting low-needs patients. He expressed frustration with the administrative process required to convert facilities to different uses and the current penalties and disincentives built into the certification and licensure inspection process. He also commented on reimbursement increases discussed in the 2007 budget negotiations that were not realized by the facilities.

Mr. Steve Smith of the Indiana Health Care Association commended the administration on the implementation of SEA 493-2003. He agreed with Secretary Roob's 10-year estimate of the time necessary to build the capacity for delivery of in-home services and suggested that if the rate structure is appropriate, the service capacity will be developed. He commented that nursing facilities are the only service providers reimbursed by Medicaid on the basis of cost. He recommended that payment for nursing facility services should be based on a daily rate fixed by acuity classifications. Mr. Smith suggested that a daily rate would provide flexibility for providers to address staff wages, benefits, training and other staff retention improvements.

Trauma Centers

Mr. Tim Kennedy representing the Indiana Hospital Association testified that there are seven certified trauma centers in Indiana; three are Level 1 centers, four are Level 2 centers. Another facility is working on the Level 2 certification process.

The Commission heard testimony from medical and administrative representatives of certified trauma centers located in the state. They addressed issues of staffing, the level of coverage required, the physicians and surgeons necessary, certification requirements, payment issues, costs, and patient volumes.

H. Scott Bierke, MD, FACS, explained that trauma centers decrease death and disabilities by targeting the treatment of serious injuries within one hour of the occurrence. Representing Clarion Hospital, a Level 1 trauma center, Dr. Bierke stated that this highest level of trauma response is staffed around the clock by medical specialists supported by additional professional clinical and diagnostic staff and facilities. He explained that patient care is not different between the three designated levels of trauma center certification but that Level 1 facilities also serve as a resource for education, research, and training.

Cary Hanni, MD, Medical Director of Trauma at Deaconess Hospital, commented that the Level 3 trauma center is certified in two states - Indiana and Illinois. Dr. Hanni explained that Deaconess is staffed entirely by private physicians - there are no residents. Dr. Hanni described the caseload of the trauma center - Deaconess serves patients from Kentucky and Illinois as well as Indiana due to the geographic location. He also addressed the issue of the administration of the trauma system, commenting that while Illinois has the oldest trauma system in the country, it has operating problems due to the lack of funding.

Lewis Jacobson, MD, a trauma surgeon at the Level 1 trauma center at IU/ Wishard Hospital, stated that Wishard was the first certified American College of Surgeons (ACS) trauma center in the state. He explained that there are designated activation levels for trauma response that are based on clinical criteria. The activation level of the response team is determined on a situation-specific basis. Dr. Jacobson explained that the trauma system is designed so that all required specialists for a patient with multiple

injuries are immediately available. He added that if a hospital is not a trauma center, the required specialists may or may not be immediately available.

Mary Aaland, MD, Trauma Medical Director at Parkview Hospital, testified that trauma is the number one cause of death for young people. She discussed the clinical criteria that constitute a trauma case and explained that the majority of injured patients do not require a full trauma response. Only 10 - 15% of emergency cases require a full response. She reviewed the geographic location of the certified trauma centers explaining that some regions of the state have good regional trauma coverage while others do not. She added that Northwest Indiana and Gary in particular, has a real problem with a lack of access to trauma care. She stated that the state needs to be organized to get patients to the most appropriate facility as fast as possible and to provide better service coverage statewide.

Jayne Mitton, Executive Director of Surgical and Trauma Services at Memorial Hospital in South Bend, discussed differences in the certification requirements for Level 1 and Level 2 trauma centers. She stated that Level 2 centers do not have university affiliation and do not provide education. She explained that Level 2 centers are required to have providers respond within 15 minutes and must have a medical director and an administrative director for trauma services. Ms. Mitton commented that it took six years of work for Memorial Hospital to develop all required services to certify as a trauma center.

Debbie Poole, the Director of Trauma at St. Mary's Medical Center in Evansville, stated that of 46,000 annual emergency department patients, 22% were classified as trauma cases. Ms. Poole discussed the issue of trauma team activation fees and the conditions required for the payment of the provider's activation fees. She explained that if a trauma patient arrives at a trauma facility without notification of imminent arrival, federal law does not allow the fees to be billed.

Ann Alley of the Indiana State Department of Health gave an update on the trauma system development activities authorized by P.L. 155-2006. ISDH funds the development activities with federal funds. The ISDH and the 50-member Advisory Task Force for Trauma System and Emergency Preparedness has worked together to develop necessary components of the trauma system. She stated that ISDH and the seven certified trauma centers will be funding a comprehensive assessment of the state's trauma system to be performed by the American College of Surgeons. The review is scheduled to begin in January 2009.

Lack of Trauma Facilities in Northwest Indiana

Claude Watts, retired CEO of Methodist Hospital in Gary, explained that Northwest Indiana has relied on trauma facilities located in Illinois. He discussed the number of trauma patients seen at Methodist and added that there are eight other hospitals located in Northwest Indiana lacking quick access to trauma facilities. Additionally, he

stated that the closest trauma center closed in July 2008, leaving two Level 1 trauma centers in Chicago available for the transfer of patients from Northwest Indiana. In response to a Commission question, Mr. Watts explained that Methodist cannot currently meet the certification requirements for a trauma center due to the lack of certain key specialists. He added that Gary competes for medical personnel in the Chicago marketplace, which requires higher remuneration packages than elsewhere in the state. Mr. Watts stated that funding assistance will be required to establish a certified trauma center in Northwest Indiana.

Michael McGee, MD, Director of Emergency Services at Methodist Hospital, discussed the need to provide funding to pay doctors to provide on-call services. He explained that paying for on-call coverage is an issue affecting hospitals all over the country. He discussed the number of trauma cases experienced in Gary and the difficulty of transferring patients to trauma centers in Illinois. He commented that the Illinois trauma centers might not accept patients from Indiana for various reasons and that this situation was exacerbated by the closure this summer of the nearest trauma center. Dr McGee described local efforts to raise funding for this initiative.

Lead Poisoning Prevention for Child Care Settings

Dr. Joan Duwve, ISDH, testified that the most common effects of lead exposure are decreased IQ levels and other cognitive and behavioral effects such as inattention, hyperactivity, and learning disabilities. She stated that there is no safe level of lead exposure for children and that lead exposure causes irreversible, lifelong damage. She added that the best way to protect children from lead exposure is to identify the problem and eliminate or control the lead risks before children are exposed. Dr. Duwve cited statistics on the number of children in daycare and studies concerning the incidence of lead hazards found in daycare settings.

Dr. Indra Frank described a situation involving the remodeling of a daycare setting located in a church Sunday school wing. Church members were reluctant to test for lead-based paint due to the expectation that confirming the presence of a lead hazard would increase the complexity and cost of the remodeling project. After Dr. Frank personally confirmed the presence of lead-based paint, the church worked with an inspector from the Marion County Health Department and performed the required work. Dr. Frank commented that the lead control work required did increase the cost of the project but with proper inspection requirements in place, the testing and remediation would have been undertaken as a matter of routine.

Diana Wallace of the Indiana Association for the Education of Young Children suggested that training programs currently required for licensed childcare providers could include information on lead poisoning risks, recognition of potential hazards, and prevention. She mentioned that childcare health consultants, county extension agents, local health departments, and the Head Start program could be potential sources of training assistance. She said that provider training should be detailed and should

emphasize that providers should encourage parents to have their children tested for lead exposure. Ms. Wallace also suggested that since licensed childcare providers' facilities are currently inspected by the state that lead-risk assessment could be added as a component of that inspection process.

Janet McCabe, the Executive Director of Improving Kids' Environment, addressed the issue of whether children are at risk of lead exposure in daycare facilities. Ms. McCabe explained that the presence of lead-based paint does not automatically equate to lead exposure but that deterioration of the paint that results in chips or dust is what results in the hazard. She added that hazards cannot be identified if no one looks for them. She discussed the difference between primary prevention which means identifying potential hazards and correcting them before a child is exposed, and secondary prevention, which is testing children and identifying them after they have been exposed.

Ms. Karle Johnson of the Marion County Lead Safe and Healthy Homes Program described the activities of the program and the kinds of lead risks revealed in the inspections performed. She stated that most lead problems are found in older homes and that often the repairs required are fairly inexpensive. She elaborated on this by explaining that repairs might include keeping the paint in a home in good shape, patching a hole in a wall, or mulching a play area to keep outside dust to a minimum. Ms. Johnson commented that the results of a child's blood-lead levels performed by the program are released only to the child's parents.

Melanie Brizzi, a consultant for the Bureau of Child Care, expressed the concern of the Bureau about linking mandatory lead inspections to the childcare licensure requirements. She said that the Bureau recognizes that licensed childcare providers already operate with higher costs due to their compliance with the existing licensure requirements. The concern is that identification of lead risks may require the Bureau to close licensed providers if they do not have sufficient funds to remediate the hazard. Ms. Brizzi said that the Bureau does not know the number of licensed providers operating in facilities or homes built before 1978 and has no way to estimate the extent of the potential problem. Additionally, they have no funds available to help licensed providers with remediation work if it is needed. She said that the Bureau supports adequate training of providers concerning lead hazards and blood-lead testing for children.

Chiropractic Services in the Healthy Indiana Plan

Pat McGuffy reported to the Commission that the Family and Social Services Administration is in the process of promulgating a rule to establish the Healthy Indiana Plan program that excludes chiropractors as covered providers. She cited Indiana Code sections that indicate the chiropractors may not be excluded from participating in the program. She stated that the Indiana State Chiropractic Association would like to have chiropractic services included in the services covered in the Healthy Indiana Plan.

Jessaca Turner-Stults, General Counsel of FSSA, responded that during the Medicaid waiver negotiation process with the Centers for Medicare and Medicaid Services, vision, dental, and chiropractic services were excluded from the plan services due to the federal waiver requirement for budget neutrality. She added that chiropractic services could be covered in the scope of work but that the health plans would have to contract with the chiropractors.

Podiatry Claims Denials in the Healthy Indiana Plan

Ms. Glenna Shelby representing the Podiatric Medical Association reported that podiatrists have encountered claims payment problems with one of the HIP health plans. This problem is related to one particular health plan as podiatry services are covered in the HIP program.

Indiana Check-up / Healthy Indiana Plan Program Update

FSSA Secretary Mitch Roob highlighted progress made in implementing various components of the Indiana Check-Up program as well as Healthy Indiana Plan application and enrollment statistics. He also discussed the reasons that applicants are being denied coverage under the HIP program. Secretary Roob reported that about $124 M in cigarette tax has been collected and $24 M has been spent for HIP. He explained that there was an intent to accumulate tax funds during the build-up of the program in order to provide for funding in later years.

Indiana Check-Up Plan II

Secretary Roob reviewed a conceptual plan to revise the Indiana Medicaid program that he referred to as Indiana Check-Up Plan II. The goals of the plan are to: (1) eliminate spend-down and expand full disability coverage to 200% of the federal poverty level, (2) provide automatic disability coverage to the SSI population, (3) expand the HIP program to cover more nonparental and parental adults, (4) implement the HIP premium assistance option for HIP participants, and (5) secure and maintain funding for the Indiana safety net. He added that part of the plan would shift Disproportionate Share Hospital (DSH) funding from the state hospitals to provide support for more nonparental adults in the HIP. The plan also proposes using the Upper Payment Limit (UPL) funding stream and a hospital provider tax to increase Medicaid hospital reimbursement rates almost to the level of Medicare rates. The Secretary emphasized that this proposal is only a concept at this time.

FSSA Eligibility Modernization Update

The Commission discussed problems that consumers have experienced as a result of the eligibility modernization project. Secretary Mich Roob explained that the agency's emergency response to disastrous flooding in numerous counties had disrupted the

implementation of the contract.

Participation of Unsubsidized Individuals in the Healthy Indiana Plan

Secretary Roob reported that FSSA has not been able to determine a way to allow the participation of unsubsidized individuals within the parameters of the federal Medicaid waiver.

MCO Contract Pharmacy Carve-out Update

Secretary Mitch Roob explained that direct Medicaid purchases for prescription drugs are eligible for manufacturer rebates that may be worth up to 38% of the cost of the drugs. The rebates are not available for prescription drugs purchased within the capitated HIP and Hoosier Healthwise programs. FSSA is proposing to remove the cost of prescription drugs from the capitated rates paid to the managed care organizations beginning in January 2010 to take advantage of available rebates. The current Medicaid Pharmacy Benefits Manager would be used to process all the drug purchasing. An initial estimate of the dollar amount of the resulting rebates indicates a potential annual state-only savings of $30 M to $40 M. Secretary Roob stated that removing the pharmacy expenditures from the capitated MCO rates could be accomplished administratively.

Mr. Joe Vanable, NAMI, stated that if the pharmacy carve-out would impede access to mental health drugs, NAMI would have concerns.

ISDH Immunization Registry Evaluation

Ms. Penny Lewis, CHIRP Project Director, gave a review of the Children and Hoosier Immunization Registry Program (CHIRP). The CHIRP registry is a free, web-based, life-span immunization registry funded through a Centers for Disease Control grant. Ms. Lewis explained that the CHIRP registry uses existing prepackaged software sold and used in eight other states. The ISDH conducts monthly user group meetings to identify problems and opportunities for potential improvements. Ms. Lewis reviewed the results of a user survey of the CHIRP product that identified that 0.06% of respondents thought the system was difficult to use. She reported on CHIRP system uses and capability and gave a demonstration of the registry.

V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Commission made the following recommendations.

PD 3262

PD 3262 requires that self-directed in-home care is available throughout the state. It establishes certain requirements for individuals that provide attendant care services and

certain requirements for the individuals in need of self-directed in-home services. The PD also requires home health agencies to report specified information. It also requires the FSSA Division of Aging to register persons providing attendant care services and to make a list of registered attendants available on request. FSSA is required to study certain information concerning self-directed in-home care and to report the results of the study to the Legislative Council no later than September 1, 2009.

A motion was made and seconded to approve PD 3262. The motion was adopted by voice vote.

PD 3255

PD 3255 creates the Trauma Care Hospital Fund to assist in funding a trauma care system in Indiana. The Fund is to be administered by the State Department of Health. The PD provides that revenue for the fund will include additional court fees for certain motor vehicle violations, registration fees, and driver's license fees.

A motion was made and seconded to approve PD 3255. The motion was adopted by unanimous voice vote.

PD 3261

PD 3261 requires self-directed in-home care options and services to be available for Medicaid waiver recipients and CHOICE program recipients. The PD requires certain Medicaid funds to follow a recipient transferring from institutional care to Medicaid home and community-based care. It also specifies services available to a Medicaid waiver recipient.

A motion was made and seconded to approve PD 3261. The motion was adopted by unanimous voice vote.

PD 3338

PD 3338 requires the FSSA Division of Family Resources to adopt rules concerning lead poisoning prevention in child care settings and sets forth issues that must be addressed in the rules. The PD requires the Division to consult with the ISDH during the rulemaking process.

A motion was made and seconded to approve PD 3338. The motion was adopted by unanimous voice vote.

PD 3432 - Attracting Primary Care Physicians for Shortage Areas

PD 3432 changes the mandate of the Medical Education Board from a focus on only family practice physicians to primary care physicians. Primary care is defined to include

family practice, obstetrics and gynecology, pediatrics, and internal medicine. The PD requires the Board to develop a plan to attract primary care physicians to areas in Indiana that do not have a sufficient number of primary care practitioners. It also changes the name of the Family Practice Residency Fund to the Primary Care Practice Residency Fund.

A motion was made and seconded. The motion to approve PD 3432 was unanimously adopted by voice vote.

PD 3415 Modernization or Privatization Contracts

PD 3415 prohibits the Office of the Secretary of FSSA from expanding the use of a contractor to assist with determinations of eligibility for the Medicaid program, the Food Stamp program, and the TANF program to an additional county after November 1, 2008, until the Office has reviewed specified provisions of the contract and reported its findings to the Select Joint Commission on Medicaid Oversight. The Commission must also review the changes and status of the process of eligibility determinations in the counties that implemented the eligibility changes before November 1, 2008.

A motion was made and seconded to approve PD 3415. The Chairperson announced the motion was adopted following a voice vote.

Approval of Final Report

A motion was made and seconded to approve the draft of the Final Report with the inclusion of the October 22, 2008, meeting testimony and the Commission's actions taken on the preliminary drafts. The motion was approved unanimously by voice vote.

W I T N E S S L I S T

August 20, 2008

Wayne Morgan, CNA, Home Health Aide
Maggie Laslo, Director of Governmental Affairs, Service Employees' International Union
Linda Muckway, Consumer
Denise Gaither, Long-term Care Consultant, C.E. Reed & Associates
Todd Stallings, Director, Indiana Association for Home & Hospice Care
Tim Kennedy, Indiana Hospital Association
Claudia Chavis, Caregiver's Home Health Services
Sara Toney, Visiting Nurse Service, Hospice Department
John Cardwell, Hoosiers First, Inc.
Al Tolbert, Executive Director, Southern Indiana Center for Independent Living
Rebecca Vaughan, Director, Indiana Long-Term Care Partnership
Dan Seitz, Association of Indiana Life Insurance Companies
Michael Fager, Genworth Financial
Marie Roche, John Hancock Insurance

September 3, 2008

Mitch Roob, Secretary, Family and Social Services Administration
Vince McGowen, Hoosier Owners and Providers for the Elderly
Steve Smith, Indiana Health Care Association
Tim Kennedy, Indiana Hospital Association
H. Scott Bierke, MD, FACS, Trauma Surgeon, Clarion Hospital
Jayne Mitton, Executive Director, Surgical and Trauma Services, Memorial Hospital, South Bend
Cary Hanni, MD, Medical Director of Trauma, Deaconess Hospital, Evansville
Lewis Jacobson, MD, Trauma Surgeon, IU/Wishard Memorial Hospital, Indianapolis
Debbie Poole, Executive Director of Trauma, St. Mary's Medical Center, Evansville
Mary Aaland, MD, Trauma Medical Director, Parkview Hospital, Fort Wayne
Claude Watts, Retired CEO, Methodist Hospital, Gary
Michael McGee, MD, Director of Emergency Services, Methodist Hospital, Gary
Kwana Shaw
John Cardwell, Director, Generations Project
Ann Alley, Director of Primary Care, Indiana State Department of Health

September 24, 2008

Senator Beverly Gard
Joan Duwve, MD, Medical Director, Human Health Services & Preparedness Commission
Melanie Brizzi, Consultant, Bureau of Child Care, Family and Social Services Administration

Indra Frank, MD
Diana Wallace, Indiana Association for the Education of Young Children
Janet McCabe, Executive Director, Improving Kids' Environment
Karle Johnson, Administrator, Lead Safe & Healthy Homes Program, Marion County
Jessaca Turner-Stults, General Counsel, Family and Social Services Administration
Pat McGuffy, Indiana State Chiropractic Association
Dr. Ferguson, President, International Chiropractor's Association of Indiana
Glenna Shelby, representing Dr. Richard Stanley, Podiatric Medical Association

October 22, 2008

Mitch Roob, Secretary, Family and Social Services Administration
Joe Vanable, NAMI Indiana
Penny Lewis, CHIRP Project Manager, ISDH